

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6012967	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/23/2020
--	--	---	---

NAME OF PROVIDER OR SUPPLIER LEXINGTON OF CHICAGO RIDGE	STREET ADDRESS, CITY, STATE, ZIP CODE 10300 SOUTHWEST HIGHWAY CHICAGO RIDGE, IL 60415
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S 000	<p>Initial Comments</p> <p>Annual Certification Survey</p> <p>Complaint Investigation</p> <p>2097281/IL126794 2098270/IL127875</p>	S 000		
S9999	<p>Final Observations</p> <p>Statement of Licensure Violations</p> <p>300.610a) 300.1210b) 300.1210d)6)</p> <p>Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing</p>	S9999	<p style="text-align: center;">Attachment A Statement of Licensure Violations</p>	

Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
---	-------	-----------

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6012967	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/23/2020
--	--	---	---

NAME OF PROVIDER OR SUPPLIER LEXINGTON OF CHICAGO RIDGE	STREET ADDRESS, CITY, STATE, ZIP CODE 10300 SOUTHWEST HIGHWAY CHICAGO RIDGE, IL 60415
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	<p>Continued From page 1</p> <p>care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.</p> <p>d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:</p> <p>6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.</p> <p>These requirements were not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to follow its Transfer, Ambulation and Re-Positioning Policy and the mechanical lift Safety Policy and assess the resident's ability to utilize the mechanical lift for 1 of 4 resident reviewed for unsafe transfer and fall with injury. This failure resulted in R190 unable to maintain an upright position during an assisted transfer using the mechanical lift from the wheelchair to the bed by staff, and R190 then complaining of pain to the left hip area. R190 sustained an acute left femoral fracture with moderate displacement.</p> <p>Findings Include:</p> <p>R190 had diagnoses including muscle weakness, difficulty walking, osteoarthritis, fatigue, muscle disorders, Alzheimer's, and Dementia. R190's Minimal Data Set (MDS) section G functional status dated 7/3/2020 documents R190 requires extensive assistance with two person physical</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6012967	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/23/2020
--	--	---	---

NAME OF PROVIDER OR SUPPLIER LEXINGTON OF CHICAGO RIDGE	STREET ADDRESS, CITY, STATE, ZIP CODE 10300 SOUTHWEST HIGHWAY CHICAGO RIDGE, IL 60415
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S9999	<p>Continued From page 2</p> <p>assist for activities of daily living assistance. R190's balance during transition and walking between bed, chair or wheelchair was documented as not steady, only able to stabilize with staff assistance. R190's range of motion for the lower extremity (hip, knee, ankle and foot) had impairment on both sides.</p> <p>On 10/21/2020 at 3:04pm, V4 (Nurse) stated, "The Certified Nursing Assistant (CNA) reported R190 complained of pain with {incontinence care}. I assessed R190. R190 pointed to her left side. I called the nurse practitioner who ordered a stat X-ray. R190 had a fracture. R47 (R190's roommate), who was alert at that time, said R190 fell and the CNA put R190 back in bed." During the investigation, R47 was asked what happened a few different times and did not change her story.</p> <p>On 10/21/2020 at 3:20pm, V10 (Charge Nurse) stated, "The CNA reported on 9/23/2020 that R190 was complaining of pain again. I assessed R190; the pain was coming from the left side. We did an x-ray on R190's left side with positive results of a fracture. R47 (R190's roommate) reported R190 fell over the weekend on a Friday during evening time. R47 reported R190 was trying to get up from the wheelchair and she fell on the left side. There was no documentation of R190's fall. R47 reported a CNA picked R190 up. I spoke with R190. R190 reported she fell when she was going to the door. We called V18 (CNA), R190's assigned CNA. I was told V17 (CNA) and V18 (CNA) transferred R190 from the wheelchair to bed with the mechanical lift (sit to stand). Maybe that's is where the fracture came from. R190 was a fall risk and a two person physical assist with transfers. R190 was lowered to the floor in the past due to her knee giving out."</p>	S9999		
-------	--	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6012967	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/23/2020
NAME OF PROVIDER OR SUPPLIER LEXINGTON OF CHICAGO RIDGE		STREET ADDRESS, CITY, STATE, ZIP CODE 10300 SOUTHWEST HIGHWAY CHICAGO RIDGE, IL 60415		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	<p>Continued From page 3</p> <p>On 10/22/2020 at 12:01pm, V2 (Director of Nursing) stated, "R190 was transferred by V17 (CNA) and V18 (CNA) using the sit to stand lift to the bed. R190 could not bear her weight. R190 slipped/dropped down in the sling but did not fall. It was not a normal transfer. R190 had a change in plain while in the sling. Maybe the weight of the change caused the fracture.</p> <p>On 10/22/2020 at 2:49pm, V19 (Physical Therapist) stated that R190 had diagnosis of Parkinson's disease. R190 was picked up for having falls. R190 had a decrease in functioning and mobility, bilateral lower extremities weakness, impaired standing balancing and low activity intolerance. R190 did not require a mechanical lift. R190 had a history of falls that were related to R190 trying to get up on her own. R190's strength was impaired in both arms. R190 might not be able to hold to the sit to stand with her cognition.</p> <p>On 10/23/2020 at 9:06am and 9:07am, V1 (Administrator), V17 (CNA) and V18 (CNA) were unavailable for interview via the phone.</p> <p>On 10/23/2020 at 12:21pm, V2 stated, "V18 (CNA) should have had retraining after R109's fall because V18 was the assigned CNA. V17 (CNA) had just completed his annual training and did not get retained."</p> <p>On 10/23/2020 at 12:40pm, V24 (Restorative Nurse) stated she did not do any retraining with V17 (CNA) and V18 (CNA) because they completed their annual training.</p> <p>Clinical Note dated 9/23/2020 documents: R190 was seen for routine monthly follow up. Later on</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6012967	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/23/2020
--	--	---	---

NAME OF PROVIDER OR SUPPLIER LEXINGTON OF CHICAGO RIDGE	STREET ADDRESS, CITY, STATE, ZIP CODE 10300 SOUTHWEST HIGHWAY CHICAGO RIDGE, IL 60415
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	<p>Continued From page 4</p> <p>today, nurse called to inform me of R190's left hip fracture, not sure what caused the fracture.</p> <p>Clinical Note dated 9/23/2020 documents: R190 complained of pain to left hip with {incontinence care}. X-ray obtained of right lower extremities and right hip showed osteoarthritis and mild osteopenia. STAT X-ray ordered for left hip.</p> <p>Caregiver Alert documents: R190 requires a two person assisted transfer with a gait belt.</p> <p>Fall Risk Assessment date 3/2/2020 documents: R190 has a balance problem with standing and walking.</p> <p>Fall Incident History: Fall occurred with standing or changing position. R190 was scored as an eight. High risk for falls is a score of ten or above.</p> <p>Event dated 9/23/2020 documents: R190 complained of left hip pain with {incontinence care}. STAT X-ray of left hip ordered.</p> <p>Final radiology report dated 9/23/2020 documents: Acute femoral fracture with moderate displacement with moderate osteopenia/osteoporosis and osteoarthritis.</p> <p>Care plan effective 2/28/2020 and 3/9/2020 documents: R190 has short term memory problems. R190 is at fall risk due to history of falls, physical limitation, balance problems, gait strength, diagnosis of Parkinson's and Alzheimer's disease. Intervention: transfer with two person assist.</p> <p>Final Reportable dated 9/28/2020 documents: R190 was unable to maintain an upright position during an assisted transfer from the wheelchair to</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6012967	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/23/2020
--	--	---	---

NAME OF PROVIDER OR SUPPLIER LEXINGTON OF CHICAGO RIDGE	STREET ADDRESS, CITY, STATE, ZIP CODE 10300 SOUTHWEST HIGHWAY CHICAGO RIDGE, IL 60415
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	<p>Continued From page 5</p> <p>the bed by staff. Injury most like occurred during transfer on 9/18/2020.</p> <p>Termination/Discipline Notice dated 8/25/2015 documents: V17 (CNA) performed inappropriate transfers which can lead to and or termination of employment.</p> <p>Termination/Discipline Notice dated 10/7/2020 documents: V18 (CNA) failed to follow policy and procedure during patient transfer resulting in patient injury. Any further occurrences will lead to termination.</p> <p>Sit to Stand Lift Safety Policy: Sit to stand lifts will be used to provide safe transfers: Refer to the manufactures' use manual for additional information.</p> <p>Sit to Stand Manual (Basic Standing Transfer) documented that a patient must have cooperative behavior, able to follow simple direction, able to put both feet on the foot pad and bear weight on both legs, able to stand erect or lean back into the back belt with arms on the outside of the back belt</p> <p>Transfer, Ambulation and Re-positioning (TARP) Policy effective 5/01: The facility will promote safety for residents during transfers.</p> <p>(B)</p>	S9999		